Social and Political Elements of Inclusive Practice

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LEARNING OBJECTIVES

At the end of this chapter, students will be able to:

- review the concept of health as a human right
- examine the origin, nature, and scope of in/exclusion
- consider the nature of inclusion at service and practice levels
- discuss the capabilities needed for inclusion in health care
- discuss problems and prospects of inclusiveness.

KEY TERMS

capabilities
health equity
human rights
right to health
special rapporteur
social in/exclusion

The right to health

Laying claim to highest attainable standard of health is a human right. Support for this right is provided by the United Nations Declaration of Human Rights (United Nations [UN], 1948) and a small number of legally binding international treaties. Among the most important of these for health are the International Covenant on Economic, Social, and Cultural Rights (ICESCR) (UN, 1966a) and the Convention on the Rights of the Child (CRC) (UN, 1989). Both these human rights treaties are legally binding for those countries that have ratified them. The ICESCR, in particular, articulates a comprehensive view of the obligations of state members of the United Nations (UN) to respect, protect and fulfil the right to the enjoyment of the highest attainable standard of physical and mental health – known as 'the right to health'. It provides for both freedoms, such as the right to be free from non-consensual and uninformed medical treatment, medical experimentation, or forced HIV testing, as well as entitlements. These entitlements include the right to a system of protection on an equal basis for all, a system of prevention, treatments and control of disease, access to essential medicines, and services for sexual and reproductive health; and access to information and education about health for everyone. The Committee on Economic, Social, and Cultural Rights (ECSCR) monitors compliance with these provisions. Most states have ratified the ICESCR, and all but two (Somalia and the US) have ratified the CRC.

Right to health

To respect, protect and fulfil the right to the enjoyment of the highest attainable standard of physical and mental health.

All countries have ratified at least one other binding treaty that includes the right to health, such as the International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1966b). Many have also included this right in their national constitutions (Kinney & Clark, 2004). The Constitution of the World Health Organization (WHO) (1946), Declaration of Alma-Ata (1978), Ottawa Charter for Health Promotion (1986) and Bangkok Charter for Health Promotion in a Globalized World (2005), agreed to by the health community also recognise this fundamental human right.

Human rights

Legally binding treaties from the United Nations that respect, protect and fulfil individuals to attain the right to the enjoyment of the highest attainable standard.

However, the signatories to these treaties seemed not to have grasped the full extent of their fiduciary obligations. For the most part, the provision of primary health care has remained the focus of government policy (Sen, 2008). There is no doubt that good health depends on quality health care. But this is not the only determinant. It is necessary, though not sufficient. Good health also depends on nutrition, lifestyle, education, people's empowerment and the extent of equality and freedom in a society. Confining the right to health to the provision of primary health care omits these important corequisites.

A deeper understanding of the right to health began to emerge after the ECSCR, working in close collaboration with WHO, drafted and adopted General Comment 14.

The comment paraded a substantive understanding of the right to health that could be made operational and improved in the light of practical experience.

General comment 14 – some important points

Article 12 of the International Covenant on Economic, Social, and Cultural Rights very briefly sets out the right to the highest attainable standard of health. General comment 14 provides the UN Committee on Economic, Social, and Cultural Rights interpretation of article 12. Although not legally binding, the comment is highly authoritative.

- Encompassing physical and mental health, the right to health places obligations on governments in relation to health care and the underlying determinants of health – these obligations include provision of clean water, adequate sanitation, nutritious food, adequate shelter, education, a safe environment, health-related information and freedom from discrimination.
- Governments have, for example, obligations regarding maternal, child, and reproductive health; healthy natural and workplace environments; the prevention, treatment and control of diseases; health facilities, services and goods.
- Governments have an obligation to give particular attention to marginal individuals, communities and populations, creating a need for as much disaggregation of data as possible.
- Within a country, health facilities, services and goods must be available in sufficient quantity, accessible, (including affordable) to everyone without discrimination, culturally acceptable (for example, respectful of medical ethics and sensitive to gender and culture) and of good quality.
- The right to health is subject to progressive realisation and resource availability.
- Nonetheless, governments must take deliberate, concrete, and targeted steps to ensure the progressive realisation of the right as expeditiously and effectively as possible.
- However, core obligations are subject to neither progressive realisation nor resource availability. Expressly taking into account the Declaration of Alma-Ata, they include obligations to ensure access to health facilities, goods, and services to everyone, including marginal groups, without discrimination; to ensure everyone is free from hunger; to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and portable water; to provide essential drugs, as defined under the WHO action programme on essential drugs; to ensure equitable distribution of all health facilities, goods, and services; and to adopt and implement a national public-health strategy and plan of action, by way of a participatory and transparent process.
- The right to health requires opportunities for as much participation as possible by individuals and communities in health-related decision making.

- Governments have an obligation to ensure that non-State stakeholders are respectful of the right to health (e.g., do not discriminate).
- Developed States, and others in a position to assist, should provide international assistance and cooperation in health to developing countries (e.g., economic and technical assistance to help developing countries fulfil their core obligations). All States have an obligation to ensure that their actions as members of international organisations take due account of the right to health.
- Monitoring, accountability and redress are essential. Given progressive realisation, indicators and benchmarks are indispensable if governments are to be held to account.
- The right to health is closely related to, and dependent upon, numerous other human rights, such as the rights to life, education, and access to information.
- In narrowly defined circumstances and as a last resort, the enjoyment of some human rights may be interfered with to achieve a public health goal. For example, quarantine for a serious communicable disease, such as Ebola fever, may, under certain circumstances, be necessary for the public good, and lawful under human rights, even though it limits an individual's freedom of movement.

(Committee on Economic, Social and Cultural Rights, 2000)

General Comment No. 14 defines the obligations that signatories have to fulfil in order to implement the right to health at the national level. These are as follows:

- The obligation to respect the right to health requires States to, inter alia, refrain from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy; and abstain from imposing discriminatory practices relating to women's health status and needs.
- The obligation to protect includes, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties. States should also ensure that third parties do not limit people's access to health-related information and services.
- The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. This obligation entails also the State to take positive measures that enable and assist individuals and communities to enjoy the right to health.
- While all the rights under the ICESCR are meant to be achieved through progressive realization, States have some minimum core obligations which are of immediate

> effect. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health, such as the preparation of a national public health strategy and plan of action. Progressive realization means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.
>
> (Committee on Economic, Social and Cultural Rights, 2000, pp. 10–11)

The promotion and protection of the right to health was further strengthened by the establishment in 2002 of the UN Special Rapporteur (UN, 2007). In accordance with General Comment 14, the Special Rapporteur highlights critical health issues, such as fluctuations in maternal mortality rates and neglected diseases among people living in developing countries, and calls attention to improperly functioning public and private health systems. The Special Rapporteur also reports cases of rights violations, and promotes the right to health amongst non-UN state actors, pharmaceutical companies among them.

Special rapporteur

The special rapporteur created by the UN, highlights critical health issues in developing countries and calls attention to improperly functioning public and private health systems. The special rapporteur also reports cases of rights violations, and promotes the right to health amongst non-UN state actors.

Having established that attaining the highest standard of health possible is a fundamental, inalienable human right. It is incumbent on right providers; that is, national governments, to create a health system capable of implementing it. The right-to-health requirements highlighted in General Comment 14, most notably, availability, accessibility, cultural acceptability, quality, participation, cooperation, monitoring and accountability, must be applied to health systems. Together, they determine what these systems need to do (for example, providing access to essential medicines) and the way that they ought to function (for example, transparently, in a participatory process, and without discrimination). The right to health mitigates the risk of these health systems being impersonal, top down, and dominated by experts, by ensuring that the well-being of individuals, communities and populations remains their central focus.

REFLECT AND APPLY

- Should health be a human right? If so, why?
- Should the right to health be given the same priority in developing and developed countries? If so, why? If not, what priority would you assign the right in these types of countries?

Health equity

In 2008 the WHO Commission on Social Determinants of Health (CSDH) released its report urging that remaining gaps in health equality be closed as soon as practicable; ideally within a generation. Few probes of this nature had matched the depth and magnitude of the CSDH's undertaking or evinced such detailed recommendations. Rarely had the impact of political factors on social inequalities in health been examined. Indeed, few studies had analysed the influence of important political variables on health outcomes (Borrell et al., 2009). The report presented a compelling case for a new approach to health encompassing concerted action on the cultural, political, social as well as economic dimensions of problems associated with availability, access and delivery. The commission took a holistic view of social determinants of health. A vital component of the new operational framework introduced in its report was inclusion. ~~Economic growth is vital for prosperity.~~

However, it must encompass those at the bottom just as much as those above them if there is to be an equal right to health (and other entitlements). The CSDH's (2008) analysis emphasised three concomitant principles of action: 1) improve the conditions of daily life (that is, the circumstances in which people are born, grow, live, work and age); 2) tackle the inequitable distribution of power, money and resources (the structural drivers of those conditions of daily life) globally, nationally and locally; and 3) measure the problem, evaluate action, expand the knowledge base, develop a professional workforce that is trained in the social determinants of health and raise public awareness about these determinants.

While health departments and their ministers were deemed crucial in realising the changes envisaged by the CSDH, and expected to take the lead in creating and supporting policies and programs that promoted health equity, taking effective action to improve the social determinants of health invariably involved the whole of government, as well as wider society, business sector and international agencies. Thus, in order for people to be genuinely and fully included amongst those able to exercise their right to the highest standard of health attainable, inclusion had to be no less cultural, political, and social, than economic.

Health equity

Use of cultural, political, social and economic dimensions of problems to address availability, access and delivery of health care.

Social in/exclusion

A domino effect feeding to deprivation and resultant disadvantage and can effect access to employment, health, social and political entities.

Health in all policies

Inclusion policies have been prominent in Europe since the 1970s. Originating in France, the concept of social inclusion has played a significant role in the development of European Union (EU) social policy since the early 1990s (Hayes et al., 2008). In the EU social inclusion policies sought to address questions about the extent to which and how both individuals and groups interact with the different social, political, and economic

institutions that surround them. The Eurostat Taskforce on Social Exclusion and Poverty Statistics (1998) defined the process of *social exclusion* as:

> a dynamic process, best described as descending levels: some disadvantages lead to exclusion, which in turn leads to more disadvantage and more social exclusion and ends up with persistent multiple (deprivation) disadvantages. Individuals, households and spatial units can be excluded from access to resources like employment, health, education, social or political life (p. 25).

In the United Kingdom, following its election in 1997, the Blair Government established a Social Exclusion Unit reporting directly to cabinet (Lister, 1998). The Millennium Survey of Poverty and Social Exclusion in Britain identifies four dimensions of exclusion:

1. impoverishment, or exclusion from adequate resources (for example, low income or deprivation)
2. labour market exclusion
3. service exclusion (for example, a lack of access to public transport or child care facilities)
4. exclusion from social relations (for example, a lack of day-to-day social contact and support, or confinement in the home due to a fear of crime or a disability) (from Levitas et al., 2007).

The problems of isolation, disengagement, and non-participation were highlighted as key issues.

With the election of the former Rudd Labour Government in November 2007, social inclusion became a key focus for social policy in Australia. In 2008, the government established a Social Inclusion Committee of Cabinet, a Social Inclusion Unit in the Department of Prime Minister and Cabinet, and the Australian Social Inclusion Board (ASIB). The Minister for Social Inclusion, Julia Gillard, described social inclusion as 'replacing a welfarist approach to helping the underprivileged with one of investing in them and their communities to bring them into the mainstream' (Gillard, 2007, p. 103)

The subsequent Labor Government under Gillard continued to pursue the policy of social inclusion, with an emphasis on notions of value and participation. The ASIB (2010) contends that in order to feel valued and to participate fully in society, all Australians needed to have the resources, opportunities, and capability to:

- learn by participating in education and training
- work by participating in employment, voluntary work and family and caring
- engage by connecting with people and using their local community resources
- have a voice so that they can influence decisions that affect them

The ASIB had a broad remit that encompassed, though did not focus on, health.

In 2010 the South Australian government took the initiative in co-hosting an international conference with WHO focusing on ways to incorporate 'Health in all Policies'. An important outcome of the conference was government commitment to 'integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services' (WHO, 2010a, p. 2). The South Australian *Public Health Act* (2011) also took account of the recommendations of the CSDH (2008) report. The legislation recognised the fact that the social determinants of health were fundamental to improving population health outcomes, included principles of sustainability, partnerships, equity and prevention, and provided a mandate for collaboration. No legislative changes were introduced at the federal government level in response to the CSDH report.

A distinct advantage pertaining to the concept of social inclusion is that it is arguably much more useful than more simplistic notions of poverty or deprivation as a tool for research and policy development and implementation. Poverty lines (which are frequently set as a percentage of the median income of the population) are problematic because of their seemingly arbitrary nature (Saunders, 2008). Moreover, while poverty lines do provide information about income, they cannot demonstrate if, or to what extent, low income results in deprivation (Costa-Font & Hernández-Quevedo, 2012). Social exclusion measures, on the other hand, reveal more about the complex nature of social disadvantage, thereby allowing a clearer understanding of how to approach the problem to emerge. On this view, raising incomes alone is not enough. There needs to be a shift in focus from what people cannot afford, to what they cannot not do, but ought to be capable of doing.

REFLECT AND APPLY

- Who should pay for the provision of health?
  - government
  - business
  - service users
  - all of the above.
- Have you or someone you know ever felt excluded from using a health service?
  - If so, how and why?
  - What was done about it?
  - What was the result?

Capabilities for inclusive practice

The Melbourne Institute of Applied Economic and Social Research developed a multidimensional capabilities approach to measuring poverty and disadvantage (Headey, 2006). This research is strongly influenced by the work of Martha Nussbaum and Amartya Sen (1993), and measures capabilities, functioning and well-being. The central tenet of this approach is that, in order to function effectively in a society, people require a wide range of capabilities, and not just an adequate income. These capabilities are interdependent, and a lack or deficiency in any of one of them will severely constrain a person's life choices. The Melbourne Institute proposed a conceptual framework that distinguished a set of capabilities and functions and their relationship to well-being (satisfaction and stress) (Table 6.1).

Capabilities

Values, skills and characteristics of individuals to achieve inclusive practice.

TABLE 6.1 Framework for multidimensional analysis of disadvantage

Low capabilities	Low functioning	Low well-being
Financial and material capabilities	Financial and material functioning	Financial stress
Human capital / employment capabilities	Employment / labour market functioning	Job stress
Health capabilities: • health disability • low life expectancy • obesity • lack of access to health services	Health functioning: • poor physical functioning • poor mental health • smoker • heavy drinker • lacks exercise • poor diet	Health satisfaction: • low self-rated health • low health satisfaction
Family and social capital/ capabilities	Family and social functioning	Satisfaction with family; life satisfaction

Source: Headey, B. (2006). *A framework for assessing poverty, disadvantage and low capabilities in Australia*, p. 18.

Particular indicators are assigned to each capability, area of functioning and well-being.

The UK Department of Health pioneered the development of ten essential capabilities for inclusive practice with mental health service users (Hope, 2004). Capability was seen in terms of values, characteristics, and skills. The 10 capabilities are:

1. working in partnership
2. respecting diversity
3. practicing ethically

4. challenging inequality
5. promoting recovery
6. identifying people's needs and strengths
7. providing service user-centred care
8. making a difference
9. promoting safety and positive risk taking
10. personal development and learning.

Sharing a common set of capabilities served to create a shared language and common purposes and practices. While focusing on mental health, these capabilities were not confined to this area of practice, and were relevant to others at risk of exclusion, such as people with learning or physical disabilities, older people, families at risk and black and ethnic minorities. In order to be used effectively, however, these capabilities require equal commitment and support from mental health and allied organsiations, staff and the general community as well as government and business.

Inclusive practices

Viewing healthcare work through the lens of a social inclusion framework may present challenges to service providers and practitioners with a more traditional approach to service delivery. For others, socially inclusive practice is just another way of describing what they already do, and have always done. However, practice that is explicitly informed by the principles of social inclusion requires a potential change in professionals' attitudes and responsibilities, to include a greater acknowledgment of the impact of a service user's socioeconomic, cultural and gender contexts. Service providers are required to work collaboratively, acknowledging the role of the community as a wider service portal. It requires an inversion of the approach that characterises particular groups as 'hard to reach', by focusing on strategies that place health care services within their reach.

Examining service provision using a social inclusion lens provides:

- an opportunity to express the ways in which services and programs are actively contributing to a social inclusion agenda, beyond business as usual
- a more comprehensive picture of the barriers and challenges to access and use of services by the disadvantaged
- a new perspective on ways that health agencies and staff can collaborate to meet the potentially multiple needs of disadvantaged people.

At a service level, adopting this perspective entails:

- reviewing the ways in which staff recruitment and induction, professional development, supervision and other human resource management processes reflect social inclusion principles

- reflecting on the ways in which the service operates in a culturally appropriate and safe manner for different ethnic groups. Cultural respect is important, otherwise strategies to be inclusive may be perceived as promoting assimilation
- reflecting on the strategies that are in place to keep all service users engaged with the service.
- reflecting upon the extent to which collaboration with other services allows for joint management of complex cases to avoid multiple, uncoordinated interventions for clients.

At the practitioner level, socially inclusive practice involves:

- reflecting on the extent to which staff members are able to engage in activities that give a voice to service users' right to health
- considering the extent to which staff members are aware of and encourage service users to access formal complaint processes, such as the ombudsman, equal opportunity and human rights agencies
- considering the extent to which respectful and non-judgmental relationships with clients are formed. This includes rooting out values that have a negative impact on work with service users (for example, stereotypes, low expectations of particular groups) and replacing a deficit- with a strengths-based approach to working with marginalised people (ASIB, 2011).

Social inclusion and the political agenda

Inclusive practice requires strong and sustained political support, particularly at the national and international level. Government action can enhance inclusiveness in at least three ways: 1) by providing or guaranteeing the right to health; 2) by facilitating and formulating policy for the equitable distribution of health products, programs and services; and (3) by gathering, monitoring and evaluating disaggregated data about health equity.

However, political commitment varies considerably between countries. Much depends on the priority accorded to health on the prevailing political and economic agenda. Affordable health care in countries, like the United States, that are politically conservative and highly reliant on a market economy, is not widespread (Lorenzoni et al., 2014). Nevertheless, political leaders who advocate economic rationalism and neoliberal policies have remained highly influential since the 1980s. These political hardliners or libertarians emerged in Britain under Margaret Thatcher, Ronald Reagan in the United States, and Australia with the election of Coalition governments under John Howard in 1996 and 2001, and more recently Tony Abbott (a former cabinet member of the Howard Government) in 2013. Neoliberals insist on minimising government intervention and expenditure, and maximising private enterprise. They contend that governments need only

sponsor and administer a basic national healthcare system for those unable to afford to insure themselves against the risk of ill-health. Indeed, the Abbott Government proposed a co-payment (originally $7) for all patients seeking medical treatment. Undoubtedly the impost disadvantaged public patients. Following considerable backlash, even after promising a reduction in the co-payment (to $5), Prime Minister Abbott ~~declared~~ the proposal 'dead, buried and cremated'. In contrast, high-income countries, which are social democratic and rely on a mixed economy, such as Norway, have managed to reduce social inequalities in health (Grimm et al., 2013).

The Global Financial Crisis (GFC) has also led countries like Italy to drastically reduce expenditure on, and hence, access to, healthcare services to those most in need (de Belvis et al., 2012). The negative repercussions of the GFC on the provision of health are even greater in low-income countries (Banoob, 2009), particularly among the rural and remote inhabitants (WHO, 2010).

Even in countries where the provision of health care is a constitutional right, such as Brazil, citizens have had to resort to taking the state to court to gain access (Wang, 2013). Consequently, litigation has made the rationalisation of health care even more precarious and inequitable, because it discriminates against those unable to afford legal representation. Those who have the means manage to procure expensive medicines and treatments from the state that deplete scare public resources.

In Australia, the ASIB was disbanded by the Abbott government. Before being abolished, the ASIB (2012) reported that a small, but significant, number of people remained excluded, with approximately five per cent (or 640,000) of the population experiencing multiple and complex disadvantage. The report stated that:

> ...while Australia is a prosperous and thriving nation, there are still too many people being left behind. The destructive effect of social inequality and exclusion diminishes the Australian community. Efforts to achieve social inclusion require commitment from all levels of government and the community. It is not just about helping people fit into existing systems and structures—it is about transforming those systems and structures to make them work for everyone (p. 1).

Indigenous populations tend to have the poorest health. In a report released in 2011, the Australian Institute of Health and Welfare revealed that the state of health among the Aboriginal and Torres Strait Islander people who comprise approximately 2.5 per cent of the total population (about 517,000) was far below the national average for non-Indigenous men, women and children (p. vii). About 80 per cent of the mortality gap (in terms of potential years of life lost) could be attributed to chronic diseases (p. ix). In 2008, Indigenous households were nearly 2.5 times as likely to be in the lowest income bracket as non-Indigenous households (p. vii). Nearly half of all Indigenous children were living in jobless families in 2006, which ~~is~~ three times the proportion of all children (p. vii).

While the commitment to inclusion and equity has varied between national governments, the right to health has also not received the attention it deserves at the global level. A recently published UN report *A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development* (2013), ~~outlines~~ the new agenda for global development following the Millennium Development Goals (MDG) set in 2000. The high-level panel of eminent persons who produced the report (Dr Susilo Bambang Yudhoyono, Ellen Johnson Sirleaf and David Cameron) notes that, 'to fulfil our vision of promoting sustainable development, we must go beyond the MDGs. They did not focus enough on reaching the very poorest and most excluded people'. The report goes on to affirm a commitment to the goal of 'ensuring healthy lives for all' (p. 16). The remit of this goal was largely absent from the previous list of MDGs, where emphasis had been placed on the alleviation of poverty thought economic growth (UN, 2000). The report proposes five health promotion targets to be pursued from 2015: 1) ending preventable under-five mortality; 2) increasing vaccination coverage; 3) reducing maternal mortality; 4) providing universal access to sexual and reproductive health services and rights; and 5) diminishing the burden of AIDS, tuberculosis, malaria, neglected tropical diseases and priority non-communicable diseases. Universal health coverage (UHC) that provided access to a broad range of affordable, high-quality essential health service was proposed as a further objective (UN, 2013, p. 38), but not a priority target (Horton, 2013).

While health outcomes were the focus of the new agenda, it fails to position health as human right. Health is seen as a mere precondition for development, and not a right in and of itself. This view contrasts with the previous commitment to General Comment 14, the WHO Constitution and other international human right treaties, made by the international community to uphold health as an inalienable human right. As stated earlier, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every individual, and not just a mere instrument of economic development that can be partially implemented. To fully realise its potential, the post-2015 development framework needed to have explicitly recognised health as human right.

The WHO (2010b) has once again urged national governments to (re)affirm their commitment to providing UHC. It estimates that 'from 20% to 40% of all health spending was wasted and could be recouped by improving efficiency, and identified continued reliance on direct payments, including user fees, as by far the greatest obstacle to progress towards UHC' (p. 4). To this end, healthcare professionals and other members of society, most particularly the excluded, have a role to play in persuading governments at all levels to make inclusion a top priority. Nongovernment, community-based organisations can and do influence resource allocations and hold public health officials accountable at national and international levels (Blas et al., 2008). Even global institutions as large and powerful as the World Bank can be moved to abandon fiscal policies it once vigorously defended such as user charges (Smith, 2013).

REFLECT AND APPLY

- In what practical ways can you, as a health practitioner, demonstrate respect for cultural diversity?
- Do you think maximising social inclusion ought to be a government's first priority? If so, why? If not, what should take priority instead?

Conclusion

Since 1948 people have had a universal right to receive essential health care. Their claim on and protection for this particular human right has deepened and grown. Governments are now obliged to provide the highest attainable standard of physical and mental health to citizens. However, apart from some core elements, progress towards the full implementation of this right is contingent on the availability of resources. Core obligations include equitable access to an adequate level of health facilities, goods and services; the provision of essential drugs, defined by WHO; and adoption and implementation of a participatory and transparent national public health strategy and plan of action; as well as freedom from hunger and access to basic shelter, housing, sanitation and water.

Progress has been slow in many countries, including affluent ones. In a number of rich countries, the right to health care has not advanced as far as it might for political rather than economic reasons. It is austere, rather than deprived, political and economic systems that restrict progress in these nations. While not all rich countries have an improvised healthcare system, these are common in poverty-stricken nations. Wether rich or poor, exclusion from health care is a major problem in all countries.

Exclusion has been recognised as a chronic problem since the 1970s. However, concerted attempts to address it have ebbed and flowed. A focus on inclusion arrived later in Australia (2008) than elsewhere, and despite the rich legacy of knowledge and experience available from other countries in response to it, was fleeting. Government interest in promoting inclusion in Australia was all but extinguished in 2013, leaving some 640,000 people experiencing multiple and complex disadvantage behind.

While the focus of government has shifted, inclusion remains an established practice in health care. Inclusive practice entails taking a broader perspective on the determinants of health and care; that is, economic, political and social, and enhancing individuals' capabilities, rather than dwelling on their incapacities. Emphasis is placed on policies and practices designed to increase access to care. Not only does achieving this necessitate making services available and affordable, but also actively empowering individuals to use the services they need. This requires reaching out to those who, for no good reason, have found themselves disenfranchised.

SUMMARY POINTS

- Health is a human right, and as such, a universal entitlement.
- The right is not confined to the provision of primary health care; that is, medicines and treatment. It also encompasses the economic, political and social determinants of health.
- The right to health is protected by a number of United Nations treaties, most notably the International Covenant on Economic, Social, and Cultural Rights and the Convention on the Rights of the Child. Countries that have ratified these treaties are obliged to take account of requirements specified in General Comment 14, to maximise inclusivity and coverage in national health systems.
- Social inclusion has been policy in Europe since the 1970s, and was given impetus in the United Kingdom following the election of the Blair government in 1997. It became social policy in Australian a decade later under the Rudd Labor government.
- Labor established the Australian Social Inclusion Board in 2008. The board had a broad remit, which included, but did not focus specifically on, health.
- The South Australian government pioneered the inclusion of health in all state policies in 2010.
- Two important features of inclusive health practice are capability and functioning, that is, enabling people to realise their full potential. Government interest and investment in inclusion has never been uniform, and has waned considerably in Australia under the Abbott Government.
- The Coalition Government abolished the ASIB in 2013. However, this does not deter health professionals from continuing to engage in inclusive practice.

CRITICAL THINKING QUESTIONS

1. Does everyone have a right to the highest attainable standard of health possible? If so, why?
2. Define the right to health and list the main agencies and instruments entrusted with its protection and advancement.
3. What, if any, difference is there between the right to health and health care?
4. Identify and describe the determinants of health. Are some determinants more important than others? If so, which ones and why? If not, why not?
5. Define what is meant by the concept of capability in the health context. List the essential capabilities. Are any of these of lesser importance than others? If so, which take precedence, and why? If not, why not?

6. Could the provision of a basic standard of national health care advocated by libertarians be taken as a contravention of UN General Comment 14? If so why? If not, why not?
7. Do social inclusion and exclusion differ? If so, explain the difference between these.
8. What is entailed in putting inclusivity into healthcare practice?

WEBLINKS

The full text of General Comment 14:
http://www.refworld.org/docid/4538838d0.html

More on the role of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health:
http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx

The CSDHs report on achieving health equity in a generation:
http://www.who.int/social_determinants/thecommission/finalreport/en/

Details of the original MDGs:
http://www.un.org/en/events/pastevents/millennium_summit.shtml

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